

Child Fatalities

Purpose

- (1) The purpose of this protocol is to describe the notification, screening, and CPS assessment requirements for Child Welfare when a *child fatality* occurs.
- (2) The requirements in this protocol also apply to a fatality of a *young adult* receiving services from Child Welfare.

Definitions

- (1) “Child fatality” in this protocol refers to a fatality of any child when:
 - (a) The fatality is alleged to be the result of abuse; or
 - (b) The deceased child, the deceased child’s sibling or a member of the deceased child’s household was the subject of a report regardless of:
 - (A) The date of the report; or
 - (B) The screening decision to close at screening or assign.
- (2) “Young Adult” means a person aged 18 through 20 years.

Cultural Awareness and Responsiveness

When Child Welfare staff become aware of a child fatality, staff must make efforts, as applicable, to gather information about the family, community, and tribal cultural practices surrounding death. Use information gathered to inform communication and engagement.

Report or Notification

All Child Welfare staff must, upon becoming aware of a *child fatality*, immediately notify the Oregon Child Abuse Hotline (ORCAH). Notification occurs whether abuse is suspected or not.

Support

When a fatality occurs and the deceased is any individual on an open CPS assessment or open case from Child Welfare, the Program Manager or designee must ensure there is a plan to support the family and impacted staff. When abuse is alleged, the support plans must be developed as

part of the Fatality Staffing.

Screening

- (1) The screener must comply with the requirements outlined in this protocol, in addition to the requirements in OAR 413-015-0200 to 413-015-0230.
- (2) The screener must complete a screening report form and determine the response as follows:
 - (a) When the *child fatality* is alleged to be the result of abuse the screener must:
 - (A) Complete a screening report form; and
 - (B) Assign the report for CPS assessment; or
 - (C) Close the report at screening when the incident alleged to result in or contribute to the *child fatality* was previously reported and assigned for CPS assessment, unless the CPS assessment is closed, and the details are substantively different from the prior report.
 - (b) When the *child fatality* is not alleged to be the result of abuse, the screener must:
 - (A) Complete a screening report form; and
 - (B) Determine whether to close at screening or assign for CPS assessment based on the criteria outlined in OAR 413-015-0211.
 - (c) When additional allegations are identified that relate to the circumstances of the fatality, the surviving siblings or other children in the household, the screener must:
 - (A) Complete a screening report form; and
 - (B) Determine whether to close at screening or assign based on the criteria outlined in OAR 413-015-0211.
 - (d) When the circumstances described in (2)(a) through (c) of this section do not apply, the information does not meet the criteria to close at screening and the information is not the responsibility of the Office of Training, Investigation and Safety (OTIS), then the information must not be documented in the Child Welfare electronic information system.
- (3) When the screener determines the report meets the criteria to assign for CPS assessment, the screener must:
 - (a) Assign the report in the county where the deceased child resided except as

described in sub paragraph (b) of this paragraph.

- (b) When a *child fatality* occurs in a substitute care setting, the report must be assigned in the county where the child was in substitute care.
- (4) When a report or notification of a *child fatality* is received by a screener, ORCAH staff must:
- (a) Immediately complete a Sensitive Issue Report (Form CF150) except as described in sub paragraph (c) of this paragraph.
 - (b) Identify fatality and the screening decision in the subject line of the email and attach a copy of the screening report form.
 - (c) When the screener receives *child fatality* information that is the responsibility of the OTIS, the screener must immediately forward the information to the OTIS and it is the responsibility of the OTIS to complete a Sensitive Issue Report.

Restrict Access to the Case Record

If the *child fatality* is alleged to be the result of abuse and is assigned for CPS assessment, a supervisor must restrict access to all Child Welfare case records related to the *child fatality*. Ensure access to the information is restricted in the following ways:

- (1) The electronic case record must be identified as a restricted case. Staff allowed access to the case record must be staff assigned to complete work on the case; and
- (2) Gather original hard copies of all Child Welfare records relating to the case. Ensure the hard copy case record is kept in a location that prevents unauthorized staff from having access.

CPS Assessment

- (1) The CPS worker must comply with the *CPS assessment* requirements outlined in this protocol, in addition to the requirements outlined in OAR 413-015-0400 to 413-015-0485.
- (2) The CPS worker may request the toxicology results on the deceased child be rushed as described in this section.
 - (a) Requests for rush toxicology may be made when one or more of the following criteria are met and the child was under five years of age at the time of death:
 - (A) Prior history or evidence of current substance use in the home or by the child's caregiver;
 - (B) Mother was breast feeding or child was the age to be breast feeding;
 - (C) Other children in the home;

- (D) Undetermined cause of death and age outside SIDS/SUID age range (over a year old); or
 - (E) Positive toxicology results would impact medical examiner's cause of death or manner of death.
- (b) Rush toxicology requests must be made as close to the time of death as possible. Delay will reduce or eliminate likelihood the request is approved.
 - (c) Law enforcement, district attorneys, designated medical professionals and Child Welfare may make the request for rush toxicology.
 - (d) The only people with the authority to approve rush toxicology requests are the State forensic pathologists.
 - (e) Requests in applicable cases may be made by contacting the pathologist on call at the state medical examiner office.
 - (f) A request does not guarantee approval.
- (3) When a *child fatality* occurs in a county other than where the child resided, a CPS worker may be assigned in the county where the death occurred to assist with the CPS assessment and participate in the fatality staffing. This CPS worker will act as a liaison between the CPS worker in the county where the child resided and local agencies in the county where the child died.
- (4) The CPS worker must gather and review the medical records of the deceased child for information relevant to the *child fatality*.
- (5) When the law enforcement investigation and a medical examiner both conclude the fatality was the result of abuse and it is confirmed there are no siblings to the deceased child and no other children in the household where the fatality occurred, the CPS worker:
- (a) May, after consulting with a CPS supervisor, complete the CPS assessment without face-to-face contact with the parents or caregivers.
 - (b) Must complete the CPS assessment and document a founded disposition based on the law enforcement investigation, Medical Examiner's report and any additional information gathered during the CPS assessment.
 - (c) Must provide notice to the reporter, the deceased child's parents, including non-custodial legal parent, caregivers, and perpetrators, as outlined in OAR 413-015-0470 (1).
- (6) When no autopsy was conducted, the CPS worker must obtain and document the cause of death as determined by a medical professional.
- (7) At the conclusion of the CPS assessment and prior to determining the CPS assessment

disposition, the CPS worker must:

- (a) Jointly review the disposition and safety decision in a staffing that includes the individuals identified in the Fatality Staffing section, paragraph (2), of this protocol.
 - (b) When the disposition is founded, document whether there is reasonable cause to believe abuse contributed to the fatality.
 - (c) When the determination is unable to determine, assure there are no additional CPS assessment activities that, if completed, would likely result in an unfounded or founded disposition.
 - (d) Address any other allegations in the CPS assessment and document the dispositions.
- (8) When a law enforcement investigation and autopsy are conducted, the CPS worker must obtain the law enforcement and medical examiner's reports. When the LEA and medical examiner's reports are received:
- (a) The CPS supervisor must forward the reports to the CPS consultant assigned to the district.
 - (b) The CPS worker must review the reports and address any new safety related information.
- (9) When the CPS worker has gathered sufficient information to make a disposition as required by OAR 413-015-1015 and to make a safety determination, and the LEA or medical examiner's report has not yet been released:
- (a) The CPS assessment must be closed; and
 - (b) When available, the CPS Supervisor and CPS worker must comply with (6)(a) and (b) of this section and place the LEA and medical examiner's report in the case record.
- (10) Prior to completion of the CPS assessment, the CPS worker and CPS supervisor must consult with a CPS consultant.
- (11) An updated Sensitive Issue Report must be completed at the conclusion of the CPS assessment, regardless of disposition.

Fatality Staffing

- (1) Unless an exception is granted by the Child Safety program manager as outlined in paragraph (5) of this section, a staffing must be completed within *three working days* of the receipt of a report of a *child fatality* that may be the result of abuse.

- (2) Fatality Staffing participants.
- (a) The Fatality Staffing must include:
 - (A) District Manager or designee;
 - (B) A Program Manager or designee;
 - (C) CPS worker, caseworker and respective supervisors assigned to current CPS assessments and open cases or designees;
 - (D) A Child Safety Consultant or other member of the Child Safety Program;
 - (b) When applicable the Fatality Staffing must also include:
 - (A) A Permanency Consultant;
 - (B) A certifier;
 - (C) A foster care coordinator;
 - (D) A Critical Incident Review Team (CIRT) Coordinator or another member of the Child Fatality Prevention and Review Program;
 - (E) A tribal representative;
 - (F) A Tribal Affairs representative;
 - (G) An ODHS employee trained in Critical Incident Stress Management (CISM); and
 - (H) A Self Sufficiency worker, law enforcement representative or other internal or external partner.
- (3) The staffing participants must:
- (a) Summarize the family history and current circumstances;
 - (b) Obtain and review all available information from other agencies including preliminary findings of the LEA investigation and results of any autopsy;
 - (c) Review the protective action plan or initial safety plan for surviving siblings or other children in the household to determine sufficiency;
 - (d) Assist in development of a supportive plan for family members;
 - (e) Discuss funeral arrangements and Child Welfare’s role in funeral arrangements, if any see [OAR 413-090-0400 “Funeral and Burial Expenses”](#);

- (f) Develop a plan of support for staff to deal with the grief and loss and consider use of the [Employee Assistance Program](#), CISM and other [supportive resources](#);
 - (g) Determine whether the case will receive group supervision; and
 - (h) Obtain information from the CIRT coordinator on the CIRT process, when applicable.
- (4) The CPS Consultant assigned to the district must document the fatality staffing in the Child Welfare electronic information system.
 - (5) An exception to completing the staffing outlined in this section, may be granted at the discretion of the Child Safety Program Manager if information from a medical professional identifies a cause of death that is inconsistent with abuse.

Group Supervision

Group supervision will be used when there is recent or extensive history and surviving siblings.

- (1) Either the Child Safety Consultant, the Permanency Consultant or both will facilitate group supervision.
- (2) Group supervision occurs after the 3-day fatality staffing.
- (3) The purpose of group supervision is to:
 - (a) Support timely child safety decisions, including identification of safety threats and addressing sufficiency of safety planning;
 - (b) Discuss potential system issues; and
 - (c) Discuss observations about historical practice and trends.
- (4) The consultant will document in a case note who participated in the group supervision and summarize any resulting action items including who is responsible for each.

Fatality Summary

Unless a CIRT is assigned to review the fatality, the Child Welfare Program Manager or designee must complete a Fatality Summary ([Form CF0326](#)) within ten business days of the completion of a founded CPS assessment when abuse resulted in or contributed to a *child fatality*.

- (1) When available, the following documents must be included as attachments to the Fatality Summary:

- (a) Law enforcement reports;
 - (b) Medical examiner's report;
 - (c) Medical records; and
 - (d) Any other documents considered significant.
- (2) The Fatality Summary must be forwarded to the CPS consultant assigned to the district.

Fatality Assigned a CIRT

When a fatality is assigned a CIRT a CIRT coordinator or a member of the Child Fatality Prevention and Review Program must contact local office leadership. See CIRT requirements outlined in OAR, 413-017-0045 to 0095.

Response to External Inquiries

All external inquiries about a *child fatality* must be directed to the [Child Welfare Communication Officer](#). The Communication Officer will develop and approve any plan to address external inquiries.